Medicare Waiver Demonstration Applicant Data Sheet

	Date Submitted
Applicant Legal Name	**Date Received by CMS**
Address (city, county, state, zip code)	**Name, telephone number and address of person to be contacted on matters involving the application.**
Descriptive Title of Applicant's Project	**Project Duration** (MM/DD/YYYY) From _____ To _____
Proposed Project	**Type of Applicant** ☐ Academic Institution ☐ Individual ☐ Profit Organization ☐ Not for Profit Organization ☐ Other, please specify
Areas Affected by Project (cities, counties, states)	
Applicant's Medicare Provider Number(s)	**Applicant's Employer Identification Number**
Is The Applicant a Medicare Provider/Organization in Good Standing?	☐ Yes ☐ No If "No", attach an explanation.
TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMLY WITH THE TERMS AND CONDITIONS OF THE AWARD AND APPLICABLE FEDERAL REQUIREMENTS IF AWARDED.	
Type Name and Title of Authorized Representative	**Telephone Number**
Signature of Authorized Representative	**Date Signed**